Jefferson Health Plans

***2024 MEDICARE PRIOR AUTHORIZATION REQUEST FORM***

Icatibant - Medicare

**Phone: 215-991-4300** **Fax back to: 866-371-3239**

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

**PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.**

| **Patient Name:** | **Prescriber Name:** |
|---|---|
| Member Number: | Fax: Phone: |
| Date of Birth: | Office Contact: |
| Line of Business: ☐ Medicare | NPI: State Lic ID: |
| Address: | Address: |
| City, State ZIP: | City, State ZIP: |
| Primary Phone: | **Specialty/facility name (if applicable):** |

☐ REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that applying the 72 hour standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

| | |
|---|---|
| Drug Name: | |
| Strength: | |
| Directions / SIG: | |

**Please attach any pertinent medical history including labs and information for this member that may support approval.**
**Please answer the following questions and sign.**

Q1. Does the patient have a documented diagnosis of hereditary angioedema (HAE)?

☐ Yes ☐ No

Q2. Is the patient 18 years of age or older?

☐ Yes ☐ No

Q3. Is the patient prescribed other drugs indicated for acute treatment of hereditary angioedema?

☐ Yes ☐ No

Q4. Is icatibant being the prescribed by or in consultation with an allergist or immunologist?

☐ Yes ☐ No

Q5. Does the prescriber want to have the medication provided by a pharmacy and covered under Medicare Part D?

☐ Yes ☐ No

Q6. Additional Information:

Q7. Requested Duration:

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| **Patient Name:** | **Prescriber Name:** |
|---|---|

☐ 12 Months

_____ _____

Prescriber Signature Date

2024 Medicare Prior Authorization Request